Prior Authorization Request
HP Enterprise Services - Nevada Medicaid and Nevada Check Up

Outpatient Rehabilitation and Therapy

Fax this request to: (866) 480-9903 Questions? Call: (800) 525-2395

DATE OF REQUEST: _____/_____/_____

REQUEST TYPE: ☐ Prior Authorization ☐ Continued Services ☐ Retrospective Review

REQUIRED FOR RETROSPECTIVE REVIEWS ONLY
This recipient was determined eligible for Medicaid benefits on: _____ /_____ /_____

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient ID:	DOB:	Phone:
Address *(include city, state, zip)*:		
Guardian Name (if applicable):		Guardian Phone:
Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:		
Other Insurance Name:	Other Insurance ID#:	

ORDERING PROVIDER INFORMATION

Ordering Provider Name:		
NPI:	Phone:	Fax:
Address *(include city, state, zip)*:		
Contact Name:		

SERVICING PROVIDER INFORMATION

Servicing Provider Name:		
NPI:	Phone:	Fax:
Address *(include city, state, zip)*:		

CLINICAL INFORMATION *Use additional sheet(s) if needed to submit all pertinent medical documentation and justification to be considered in the determination of this request.*

Is this request for Healthy Kids (EPSDT) referral/services? ☐ Yes ☐ No

Diagnosis (include ICD-9 codes and descriptions):

REQUESTED SERVICES *(enter one code per line)*

CPT Code and Description	Units Requested per Week	Number of Weeks	HP ENTERPRISE SERVICES USE ONLY: Units Approved	Weeks Approved	Status	Action Code
1.						
2.						
3.						
4.						

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Recipient Name:	**Recipient ID:**
Functional Deficits and Rehabilitation Diagnoses:	
Treatment Goals:	
Previous Service or Treatment and Outcome or Results (include dates of prior services):	
Other Clinical Information Supporting the Medical Necessity of Requested Services:	

HP ENTERPRISE SERVICES USE ONLY

Dates Approved: From _____/_____/_____ To _____/_____/_____

Dates Denied: From _____/_____/_____ To _____/_____/_____

Reviewer Signature: _____ Date: _____

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged, confidential and only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.